

Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, September 23, 2014 at the hour of 10:00 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Collens called the meeting to order.

Present: Chairman Lewis M. Collens and Director Wayne M. Lerner (2)

Director Ada Mary Gugenheim and Mr. Patrick T. Driscoll, Jr. (non-Director Member)

Present

Telephonically Director Luis Muñoz, MD, MPH (1)

Absent: None (0)

Chairman Collens stated that Director Muñoz was unable to be physically present, but was able to participate in the meeting telephonically.

Director Lerner, seconded by Chairman Collens, moved to allow Director Muñoz to participate as a voting member for this meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Director Muñoz indicated his presence telephonically.

Additional attendees and/or presenters were:

Krishna Das, MD – System Chief Quality Officer
Anwer Hussain, MD – Provident Hospital of Cook
County
Randolph Johnston – System Associate General
Counsel

Deborah Santana – Secretary to the Board
Joyce Schoonover – System Director of Risk
Management
John Jay Shannon, MD –Chief Executive Officer

II. Public Speakers

Chairman Collens asked the Secretary to call upon the registered public speakers.

The Secretary called upon the following registered public speaker:

1. George Blakemore Concerned Citizen

III. Report from System Chief Quality Officer

A. Regulatory and Accreditation Updates

Dr. Krishna Das, System Chief Quality Officer, provided updates on the following subjects.

III. Report from System Chief Quality Officer

A. Regulatory and Accreditation Updates (continued)

Dr. Das stated that the visit from the surveyors from The Joint Commission at Provident Hospital is coming up; the window is very close, and needs to take place in the next three weeks. The preparations for the visit are essentially complete.

Dr. Das reported that the Cancer Program has received full accreditation for the next three (3) years from the American College of Surgeons.

B. Publicly Reported Ratings

There was nothing to report on this subject at this time.

IV. Action Items

A. Proposed Patient Safety Plan – Stroger Hospital (Attachment #1)

Dr. Das reviewed the presentation regarding the proposed Patient Safety Plan – Stroger Hospital. The Committee reviewed and discussed the information.

During the discussion of the information presented on dashboards and the Committee's role, Chairman Collens commented that this is the dashboard that should be front and center for the Committee and should be the core review focus, as well as including other issues that arise in terms of monitoring of other things.

Director Lerner inquired whether staff has quantified the measures as to what the targets are and what the benchmarks are for 2015. Dr. Das responded that exact targets have not been set. In terms of adverse events and medication errors, she stated that she would like to track how many events are being reported into the event reporting system. She guessed that the number of events will rise, as the reporting continues to improve. Director Lerner suggested that further thought be given to taking them back and seeing if she can quantify them and set up some quantifiable targets.

Mr. Driscoll commented on the subject of litigation cases involving the System that are presented to the County Board's Subcommittee on Litigation; he stated that often information is provided to that Subcommittee regarding the System's review of what transpired relating to the cases, and any corrective actions that have been taken. Dr. John Jay Shannon, Chief Executive Officer, stated that one of the problems with this is the latency of when something bubbles along and gets to the Litigation Subcommittee and when the event actually happened, and where was the organizational safety learning around that. Many organizations will use historical trending of the number of litigated cases and settlement amounts for those cases as an important health system metric, to know if they are making progress. This is not a trend that is based on a small number of events, so one has to be careful about it, but one of the things that a mature organization can see is a reduction in those events and settlements over time, largely as a function of improvement, both in their safety processes, but also the way in which they are interacting with the patients. He suggested that this should be one of the things that the Board should be following; he added that staff will come back with more explicit recommendations on that. Additionally, he noted that the culture of safety survey results themselves are an important metric to follow; those should also be included.

Director Lerner, seconded by Chairman Collens, moved to approve the proposed Patient Safety Plan for Stroger Hospital. THE MOTION CARRIED UNANIMOUSLY.

IV. Action Items (continued)

B. Minutes of the Quality and Patient Safety Committee Meeting, August 26, 2014

Director Lerner, seconded by Chairman Collens, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of August 26, 2014. THE MOTION CARRIED UNANIMOUSLY.

C. **Medical Staff Appointments/Re-appointments/Changes (Attachment #2)

Director Lerner, seconded by Chairman Collens, moved to approve the Medical Staff appointments/reappointments/changes. THE MOTION CARRIED UNANIMOUSLY.

D. Any items listed under Sections IV, V and VI

V. Recommendations, Discussion/Information Items

A. Reports from the Medical Staff Executive Committees

- i. Provident Hospital of Cook County**
- ii. John H. Stroger, Jr. Hospital of Cook County**

Dr. Ozuru Ukoha, President of the Executive Medical Staff (EMS) of John H. Stroger, Jr. Hospital of Cook County, was unable to attend due to a work-related matter.

Dr. Anwer Hussain, President of the EMS of Provident Hospital of Cook County, provided his report. He stated that there is now an eye clinic at Provident Hospital that is open five (5) days per week; the clinic opened just a few weeks ago. He thanked the leaders who made this clinic opening possible.

VI. Closed Meeting Items

A. Medical Staff Appointments/Re-appointments/Changes

B. Litigation Matter(s)

The Committee did not recess the open meeting and convene in a closed meeting.

VII. Adjourn

As the agenda was exhausted, Chairman Collens declared that the meeting was ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Lewis M. Collens, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
September 23, 2014

ATTACHMENT #1

Patient Safety Plan Overview

Stroger Hospital Safety Plan

CCHHS Board Quality and Patient Safety Committee
September 23rd , 2014

Krishna Das, MD, Chief Quality Officer

Purpose and Goals of the Plan

The patient safety plan creates a foundation for improving patient safety through:

- A standardized method of categorizing events
- Proactive approaches to reduce harm and adverse events
- The development and maintenance of a positive patient safety culture
- Communication of patient safety priority areas

The plan aligns with expert and regulatory organizations

- Institute of Medicine
- Institute for Healthcare Improvement
- CMS (Centers for Medicare & Medicaid Services)
- Joint Commission
- AHRQ (Agency for Healthcare Research and Quality)
- NQF (National Quality Foundation)
- The plan sets a blueprint for patient safety plans at all facilities at CCHHS

The Patient Safety Plan

CCHHS is committed to a comprehensive approach to ensuring patient safety and quality, including developing a culture of safety that includes an organization-wide commitment to continuous learning.

- The Patient Safety Plan for each facility places less focus on events, errors and outcomes, and more focus on risk, system design and the management of behavioral choices.
- The Patient Safety Plan and all related activities at each facility are conducted in a manner consistent with the CCHHS mission and with organization-wide performance improvement activities.

Patient Safety Dashboard I (Stroger Hospital)

PERFORMANCE MEASURES	DOMAIN [¥]	DATA SOURCE	MEASURE ORIGIN
Leadership Expectations & Actions Promoting Safety	S	Culture of Safety Survey	AHRQ*
Leadership Support for Patient Safety	S		
Staffing	S		
Handoffs & Transitions	S		
Teamwork within Units	S		
Teamwork across units	S		
Non-punitive Response to Error	S		
Feedback & Communication about Error	S		
Culture of Safety Leadership Structures & Systems	S	Leapfrog Safety Survey	NQF*
Culture Measurement, Feedback, & Intervention	S		
Teamwork Training & Skill Building	S		
Identification and Mitigation of Risks & Hazards	S		
Nursing Workforce	S		
Medication Reconciliation	S		
Hand Hygiene	S		
Care of the Ventilated Patient	S		
CPOE	S		
ICU Physician Staffing	S		
National Patient Safety Goals			
Identify Patients Correctly	P	Cerner, Meaningful Use	TJC*
Medication Reconciliation	P		
Use Alarms Safely	P		
Handwashing Compliance	P		

[¥] Domain: S = Structure, P = Process, O = Outcome

* AHRQ: Agency for Healthcare Research & Quality

NQF: National Quality Forum

TJC: The Joint Commission

CMS: Centers for Medicare & Medicaid Services

CDC, NHSN: Centers for Disease Control, National Healthcare Safety

Patient Safety Dashboard II (Stroger Hospital)

PERFORMANCE MEASURES	DOMAIN [¥]	DATA SOURCE	MEASURE ORIGIN
Hospital Acquired Conditions (HACs)			
Foreign Object Retained	O	Cerner, Administrative Reports	CMS*
Air Embolism	O		
Pressure Ulcer (Stage 3 and 4)	O		
Falls and Trauma	O		
Hospital Acquired Infections (HAIs)			
CLABSI	O	CDC, NHSN*	CMS
CAUTI	O		
SSI	O		
VAP	O		
Patient Safety Indicators (PSIs): VBP Measure			
AHRQ PSI-90 Patient Safety for Selected Indicators (Composite) [^]	O	CMS	AHRQ*
PSI 4: Death Among Surgical Inpatients	O	Cerner, Administrative Reports	
PSI 6: Iatrogenic Pneumothorax	O		
PSI 11: Postoperative Respiratory Failure	O		
PSI 12: Postopertaive PE/DVT	O		
PSI 14: Postopertiave Wound Dehiscence	O		
PSI 15: Accidental Puncture or Laceration	O		
Other			
Overall Perceptions of Safety	O	Culture of Safety Survey	AHRQ
Hospital Wide Oversight Committee	O	Internal	NA
Mortality Report	O	Internal	CMS
Readmission Report	O	Internal	CMS

[¥] Domain: S = Structure, P = Process, O = Outcome

^{*} AHRQ: Agency for Healthcare Research & Quality
NQF: National Quality Forum

TJC: The Joint Commission

CMS: Centers for Medicare & Medicaid Services

CDC, NHSN: Centers for Disease Control, National Healthcare Safety

Priority Areas: 2015

- Adverse drug events and medication errors
- Hospital acquired infections
 - Central line infections
 - Urinary tract infections
- Hospital acquired conditions/ nursing sensitive indicators
 - Falls with injury
 - Pressure ulcers

Data and Measures

Data helps us make the right decisions, particularly when patterns and trends are observed, using various measurement strategies.

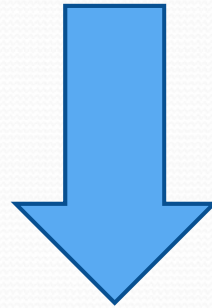
Measurement Strategies	Advantages	Disadvantages
Retrospective Chart Review	Considered the “gold standard” due to ability to obtain rich detailed clinical information.	Costly, labor-intensive, and consists only of a retrospective review.
Voluntary Event Reporting System	Useful for internal quality improvement and case-finding, highlights adverse events that providers’ perceive as important.	Capture small fraction of adverse events, retrospective review only based on provider self-reports, no standardization or uniformity of adverse events reported.
Automated Surveillance	Can be used retrospectively or prospectively, helpful in screening patients who may be at high risk for adverse events using standardized protocols.	Need electronic data to run automated surveillance, high proportion of “triggered” cases can be false positives.
Administrative/Claims Data	Low-cost, readily available data, useful for tracking events over time across large populations, can identify “potential” adverse events.	Lack detailed clinical data, concerns over variability and inaccuracy of ICD-9-CM codes across and within systems, may detect high proportion of false positives.

Analysis of Events

- All reported events or those identified by trigger tools are reviewed by quality staff
 - Events which meet specific criteria (ie sentinel events) are referred for further analysis
 - eMERS events are reviewed by management
 - Hospital acquired conditions receive initial review in committee
- Analysis of events
 - Root Cause Analyses (RCA)
 - Departmental Oversight Committees
 - Departmental M&Ms and case discussions
- Formal RCA is required for Joint Commission and IDPH reporting
- Remediation by interdisciplinary teams or departmental initiatives

Creating a Learning Culture

Errors are Treasures



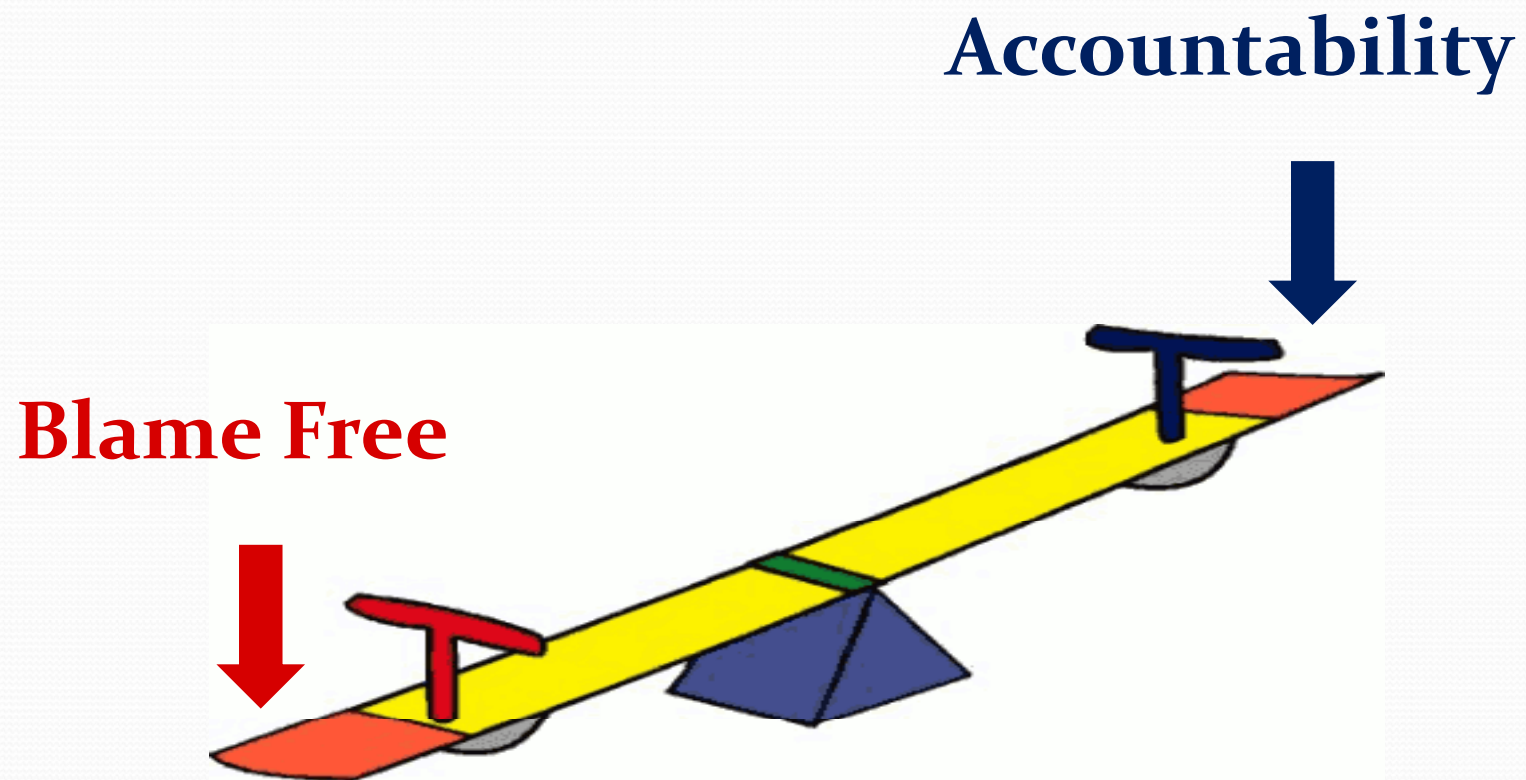
Translate errors into education.



Goal: Balance Safety & Accountability

- Improving patient safety is about changing the culture from one of blame to one where we examine our processes and systems to reduce the opportunities for mistakes.
- Not WHO caused the incident but WHAT caused the incident.
- Individual accountability is not erased

'Blame free' culture versus 'Just culture'



“Good Catch” Program & Alignment with ACGME

- A patient safety initiative to encourage staff to identify and report potential system errors before they reach the patient and cause harm.
- The program will recognize staff for identifying such “good catches” and key findings will be shared across the organization.

GOALS:

- Strengthen the culture of safety
- Allow staff to be recognized for their contributions
- Create a learning culture through a non-punitive environment

**John H. Stroger, Jr. Hospital
2015 Patient Safety Plan**

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I. Commitment to Patient Safety

John H. Stroger, Jr. Hospital (Stroger Hospital) is committed to a comprehensive approach to patient safety and quality, including developing a culture of safety that includes an organization-wide commitment to continuous learning.

A comprehensive approach lies at the heart of both evidence-based medicine and modern quality and patient safety approaches. This encompasses a consistent set of expectations, guidelines, tools and training applied by and to everyone associated with the organization from the Board of Directors, medical staff and employees and supports a learning culture leading to a “Just Culture” environment.

Stroger Hospital uses a learning culture to implement organizational improvement in order to influence Stroger Hospital’s ability to create the patient outcomes desired. The Patient Safety Plan places less focus on events, errors and outcomes, and more focus on risk, system design and the management of behavioral choices. With this system, Stroger Hospital strongly encourages an environment of free and open reporting within process systems. This helps to build a culture which encourages coaching and honesty at all levels, in order to bring about the best possible outcomes.

The development and implementation of a comprehensive plan of improvement further demonstrates evidence of the commitment to quality and patient safety. This Patient Safety Plan seeks to systematically raise the level of organizational performance through the collaboration of the Board of Directors, leadership, medical staff and ultimately all employees of the hospital.

The Board of Directors will commit the appropriate human and financial resources to assure the integrity and sustainability of the patient safety program.

The purpose of the patient safety plan is to create a foundation, aligned with the Quality Assessment and Performance Improvement Plan (Quality Plan), for improving patient safety through:

1. A standardized method to categorizing events and also classifying events based on level of harm,
2. The implementation of advanced measurement tools for identifying adverse events,
3. Proactive approaches to reduce harm and adverse events, and
4. A governance structure that elevates communication throughout the organization and ensures accountability for the established patient safety priorities.

II. Foundation for the Patient Safety Plan

The Patient Safety Plan and all related activities are conducted in a manner consistent with Stroger Hospital’s mission.

John H. Stroger, Jr. Hospital of CCHHS’ mission is to deliver integrated health services with dignity and respect regardless of a patient’s ability to pay; to foster partnerships with other health providers and communities to enhance the health of the public; and to advocate for policies which promote and protect the physical, mental and social well-being of the people of Cook County.

The Patient Safety Plan provides guidance to the overall safe practices at Stroger Hospital by aligning with the Institute for Healthcare Improvement (IHI), the National Quality Forum, the Centers for Medicare and Medicaid Services, the Joint Commission, the Agency for Healthcare Quality (AHRQ), and the American Society for Quality (ASQ), placing the patient at the center and incorporating evidence-based practice guidelines to the delivery of care. Together with the Quality Plan, Stroger Hospital has established an organization-wide, integrated patient safety program within its performance improvement activities.

III. Definitions

The National Patient Safety Foundation (NPSF) has defined the characteristics of **patient safety** as “the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care itself.”

The Agency for Healthcare Research Quality (AHRQ) defines **patient safety** as “a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

The definition used for **harm** is aligned with the Institute for Healthcare Improvement (IHI) and is as follows: unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that result in death.

An **error** is commonly defined as an act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome.

A **near miss** is an unplanned event that did not result in injury, illness or damage – but had the potential to do so.

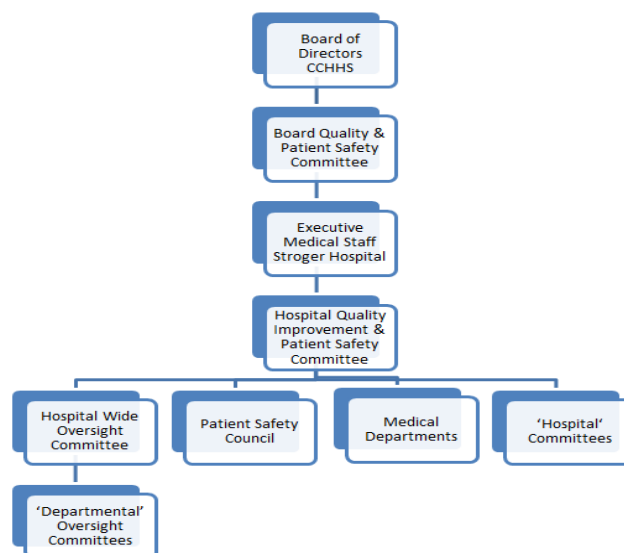
An **adverse event** is defined as events which are unintended consequences of medical care, whether preventable or not.

The Joint Commission defines a **sentinel event** as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

A **Root Cause Analysis (RCA)** is a systematic investigation technique that uses information gathered during an intense assessment of an undesirable event to determine the underlying reasons for the deficiencies or failures.

IV. Roles and Responsibility

The Patient Safety Plan supports the organizational structure established by the CCHHS Board of Directors.



Communication between all the elements of the structure is essential for the successful implementation of this plan and is further outlined in the Quality Plan.

The CCHHS Board of Directors:

- Is accountable and ultimately responsible for holding senior management, leaders and managers accountable for the quality improvement goals and ensuring that they are integrated with the organization's strategic initiatives;
- Ensures that the necessary appropriate human and financial resources and processes are in place to keep patients safe;
- Ensures all patients will be provided with the highest-quality care possible while incorporating the foundations of the Quality Plan;
- Reviews summaries of improvement activities and performance indicators to track results of overall performance; and
- Establishes committees and subcommittees as necessary to fulfill their role of the overseer of patient safety (*The Hospital Quality Improvement & Patient Safety Committee shall provide oversight and direction for implementation of the Patient Safety Plan.*).

The Board Quality & Patient Safety Committee:

- Oversees the quality and patient safety activities within the organization;
- Ensures that the organization takes a proactive approach to planning for patient safety;
- Ensures that an integrated safety program exists within the organization;
- Establishes priorities for performance improvement to the medical staff and quality committees;
- Oversee reports to the Board of Directors regarding the effectiveness of the Hospital Quality Improvement & Patient Safety Committee and recommended revisions to the Committees.

The Executive Medical Staff Stroger Hospital:

- Oversees the quality and patient safety activities within the organization;
- Ensures that the organization takes a proactive approach to planning for patient safety;
- Ensures that an integrated safety program exists within the organization;
- Approves the minutes and activities of the Hospital Quality Improvement and Patient Safety Committee prior to presentation to the Board of Directors;
- Establishes priorities for performance improvement; and
- Champions and extends concepts embodied in CCHHS' mission and related areas of learning and process improvement throughout the medical staff.

The Hospital Quality Improvement & Patient Safety Committee (Quality Committee):

- Serves the dual function of oversight of the Quality Program as well as the Patient Safety Program;
- Reviews all quality metrics, departmental and committee quality data, and prioritizes performance improvement projects;
- Reports the activities of the committee to the Executive Medical Staff;
- Provides leadership for measuring, assessing and improving systems and processes;
- Establishes priorities for performance improvement and monitors progress toward the achievement of the plans; and
- Champions and extends concepts embodied in CCHHS' mission and related areas of learning and process improvement throughout the organization.

The Hospital Wide Oversight Committee:

- Evaluates significant events in collaboration with 'Departmental Oversight Committees';
- Presents results of investigations and recommendations for performance improvement to the Quality Committee;
- Reports all significant events and results of the evaluation of such events to the Executive Medical Staff;
- Provides direction to the organization on patient safety matters;

- Provides guidance and support for hospital-wide patient safety efforts;
- Promotes a culture of safety through the coordination and implementation of patient safety programs; and
- Approves initiatives and activities to improve patient safety throughout the hospital.

The Patient Safety Council:

- Will be established as a multidisciplinary committee that is responsible for coordinating and implementing patient safety programs and initiatives, including directing and overseeing proactive risk reduction and patient safety;
- Evaluates trends from patient safety reports, adverse event analysis and other sources;
- Oversees mandatory reporting of safety events to external organizations and regulators;
- Prioritizes and recommends actions to improve patient safety throughout the hospital to the Quality Committee;
- Recognizes and celebrates successful improvement efforts related to patient safety; and
- Recommends revisions and development of policies and procedures related to patient safety to the Quality Committee.

The Department of Quality and Patient Safety:

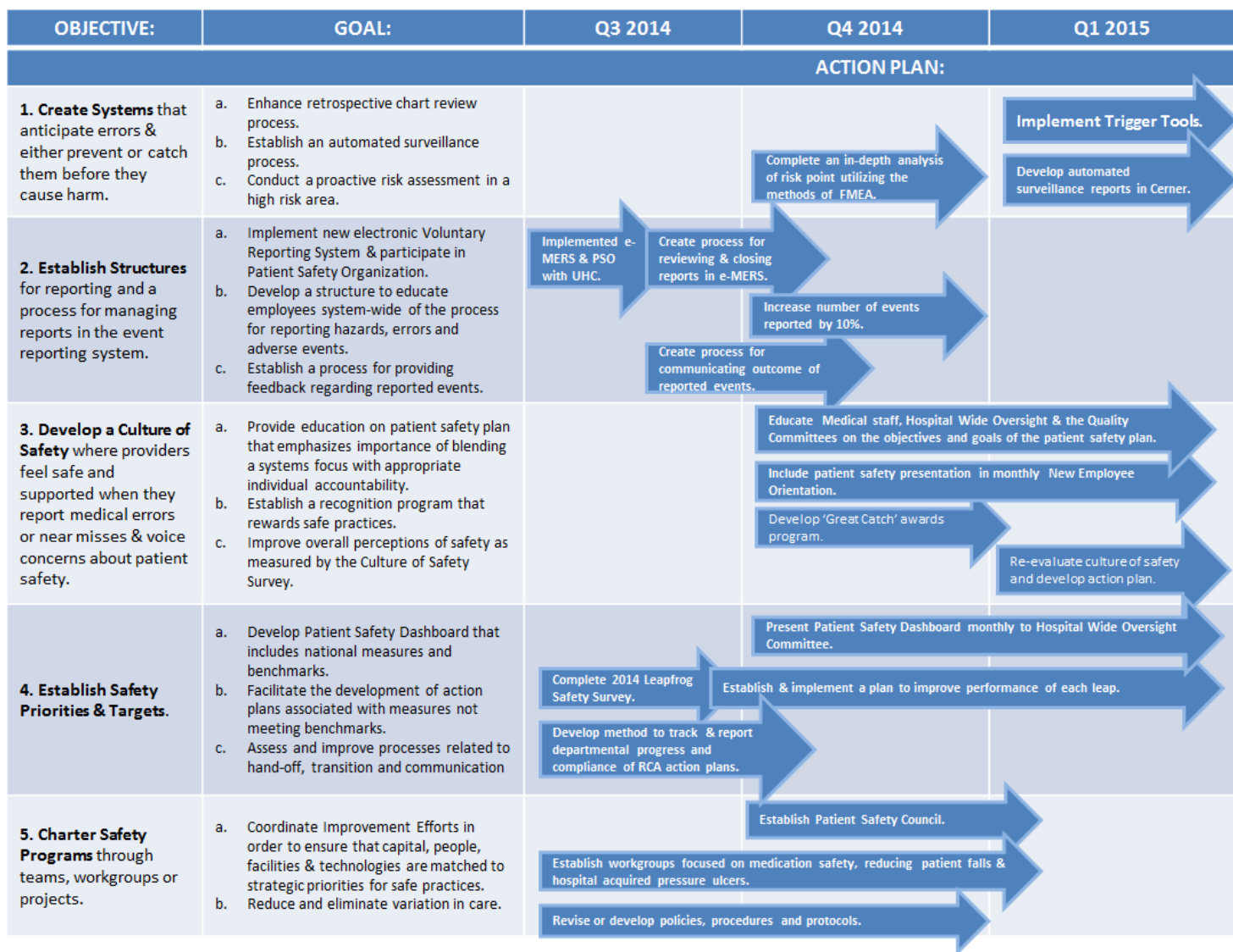
- Is responsible for the implementation of the Patient Safety Plan led by the Chief Quality Officer and executed in collaboration with the Hospital Wide Oversight and Quality Committees, departmental quality committees, hospital and system leadership and the System Departments of Risk Management, Legal, and Compliance;
- Ensures alignment among the Quality Assessment and Performance Improvement Plan and the Patient Safety Plan;
- In collaboration with the Department of Risk Management, is accountable to establishing the workflow in reviewing, managing, and closing reports within the voluntary event reporting system;
- Provides education and training to staff, leadership and physicians regarding new safety practices, measuring safety outcomes, and developing programs to improve them;
- Supervises the approach to serious events and to preventing future errors;
- Collaborates with members of the leadership team to create and implement performance improvement plans;
- Leads and coordinates Performance Improvement (PI) projects hospital-wide and educates PI concepts;
- Provides recommended methodologies to capture, analyze and report data throughout the organization;
- Ensures data are targeted to improve safety, efficiency and quality of patient care;
- Analyzes data for trends and provides consultative assistance with data analysis to foster a widespread understanding of processes to drive performance improvement; and
- Leads on-going education and training to staff at all levels, including Medical Staff, to improve compliance, quality and patient safety throughout the organization.

V. Objectives and Goals of the Patient Safety Plan

To facilitate the achievement of the mission and strategic goals, as well as promote safe practices, the Patient Safety Plan is specifically designed to encompass the following objectives:

- Create systems** that anticipate errors and either prevent or catch them before they cause harm;
- Establish structures** for reporting and a process for managing reports in the event reporting system;
- Develop a culture of safety** where providers feel safe and supported when they report medical errors or near misses and voice concerns about patient safety; and
- Establish safety priorities and targets**; and
- Charter safety programs** through teams, workgroups or projects.

The Patient Safety plan addresses the following key components and its applicable goals:



VI. Assessment of Patient Safety

Data helps organizations make the right decisions, particularly when patterns and trends are observed. Data is necessary to evaluate the hospital-wide safety program through an analysis of potential system failures and reported adverse events and near misses. Safety and harm at an institution may be measured along three domains: structure, process and outcomes. Structural measures describe systems in place at the institution which support safety, as well as specific aspects of staffing and training. Process measures are those systems of care most likely to impact patient safety, and the outcomes represent the actual impact on patients.

An assessment of the most recent data (Quarter 2 2014) included the following results from the culture of safety survey, summary data from the Leapfrog Safety Survey, data from the voluntary event reporting system and harm measures embedded in the claims data bases as reported to CMS (Centers for Medicare and Medicaid Services). The performance measures are summarized in the table below.

PERFORMANCE MEASURES	DOMAIN [¥]	DATA SOURCE	MEASURE ORIGIN
John H. Stroger, Jr. Hospital			
Leadership Expectations & Actions Promoting Safety	S	Culture of Safety Survey	AHRQ*
Leadership Support for Patient Safety	S		
Staffing	S		
Handoffs & Transitions	S		
Teamwork within Units	S		
Teamwork across units	S		
Non-punitive Response to Error	S		
Feedback & Communication about Error	S		
Culture of Safety Leadership Structures & Systems	S	Leapfrog Safety Survey	NQF*
Culture Measurement, Feedback, & Intervention	S		
Teamwork Training & Skill Building	S		
Identification and Mitigation of Risks & Hazards	S		
Nursing Workforce	S		
Medication Reconciliation	S		
Hand Hygiene	S		
Care of the Ventilated Patient	S		
CPOE	S		
ICU Physician Staffing	S		
National Patient Safety Goals			
Identify Patients Correctly (# of Identified Errors/# Observations)	P	Cerner, Meaningful Use	TJC*
Medication Reconciliation	P		
Use Alarms Safely (# of Alarms Not Responded to/# of Simulations)	P		
Handwashing Compliance (average)			
Compliance BEFORE Patient/Env Contact	P		
Compliance AFTER Patient/Env Contact			
Hospital Acquired Conditions (HACs)			
Foreign Object Retained	O	Cerner, Administrative Reports	CMS*
Air Embolism	O		
Pressure Ulcer (Stage 3 and 4)	O		
Falls and Trauma	O		
Hospital Acquired Infections (HAIs)			
CLABSI	O	Cerner, Administrative Reports	CMS, CDC, NHSN*
CAUTI	O		
SSI	O		
VAP	O		
Patient Safety Indicators (PSIs): VBP Measure			
AHRQ PSI-90 Patient Safety for Selected Indicators (Composite) ^	O	CMS	AHRQ*
PSI 4: Death Among Surgical Inpatients	O	Cerner, Administrative Reports	
PSI 6: Iatrogenic Pneumothorax	O		
PSI 11: Postoperative Respiratory Failure	O		
PSI 12: Postoperative PE/DVT	O		
PSI 14: Postoperative Wound Dehiscence	O		
PSI 15: Accidental Puncture or Laceration	O		
Other			
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Mortality Report	O	Internal	CMS
Readmission Report	O	Internal	CMS

[‡] Domain: S = Structure, P = Process, O = Outcome

* AHRQ: Agency for Healthcare Research & Quality

NQF: National Quality Forum

TJC: The Joint Commission

CMS: Centers for Medicare & Medicaid Services

CDC, NHSN: Centers for Disease Control, National Healthcare Safety

VII. Specific Outcome Measures

- A. One of the greatest challenges in measuring and improving patient safety is the correct identification of patient safety events. The following table highlights some of the advantages and disadvantages of the most common methods of measuring errors and safety events. The scope of the Patient Safety program includes the full range of safety issues, from near misses to sentinel events *also classified by NQF and CMS as serious reportable events.

Measurement Strategies	Advantages	Disadvantages
Retrospective Chart Review	Considered the “gold standard” due to ability to obtain rich detailed clinical information.	Costly, labor-intensive, and consists only of a retrospective review.
Voluntary Event Reporting System	Useful for internal quality improvement and case-finding, highlights adverse events of which providers’ perceive as important.	Capture small fraction of adverse events, retrospective review only based on provider self-reports, no standardization or uniformity of adverse events reported.
Automated Surveillance and Trigger Tools	Can be used retrospectively or prospectively to help screen patients who may be at high risk for adverse events using standardized protocols.	Need electronic data to run automated surveillance, high proportion of “triggered” cases can be false positives.
Administrative/Claims Data	Low-cost, readily available data, useful for tracking events over time across large populations, can identify “potential” adverse events.	Delayed results, concerns over variability and inaccuracy of ICD-9-CM codes across and within systems, may detect high proportion of false positives thereby requiring additional chart review.

- B. This table provides additional performance indicators for measuring, analyzing and improving patient safety. Several studies have reported the increased use by hospitals of trigger tools to detect adverse events through the screening of medical records for certain triggers which may suggest that an adverse event has occurred. As a well-developed, well-documented, and publicly available approach to detect adverse events in hospital patients, the trigger tool measures can advance patient safety by identifying trends and areas of potential concern. These measures will be evaluated and reported to the Hospital Wide Oversight Committee as noted within the action plan of the Objectives and Goals section.

Trigger Tool Measures	DOMAIN [¥]	DATA SOURCE	MEASURE ORIGIN
<i>Adverse events per 1,000 patient days</i>	O	Cerner, Administrative Data	NA
<i>Adverse events per 100 admissions</i>	O		
<i>Percent of admissions with an adverse event</i>	O		
<i>Care Module Triggers</i>	O		
Any code or arrest	O		
Mortality	O		
Readmission within 30 days	O		
<i>Medication Module Triggers</i>	O		
PTT >100 s	O		
INR >6	O		
Vitamin K administration	O		
Narcan (Naloxone) use	O		
<i>Surgical Module Triggers</i>	O		
Return to surgery	O		
Intubation/reintubation in postanesthesia care unit	O		
Intra- or postoperative death	O		
<i>Intensive Care Module Triggers</i>	O		
Readmission to intensive care	O		
Intubation/reintubation	O		

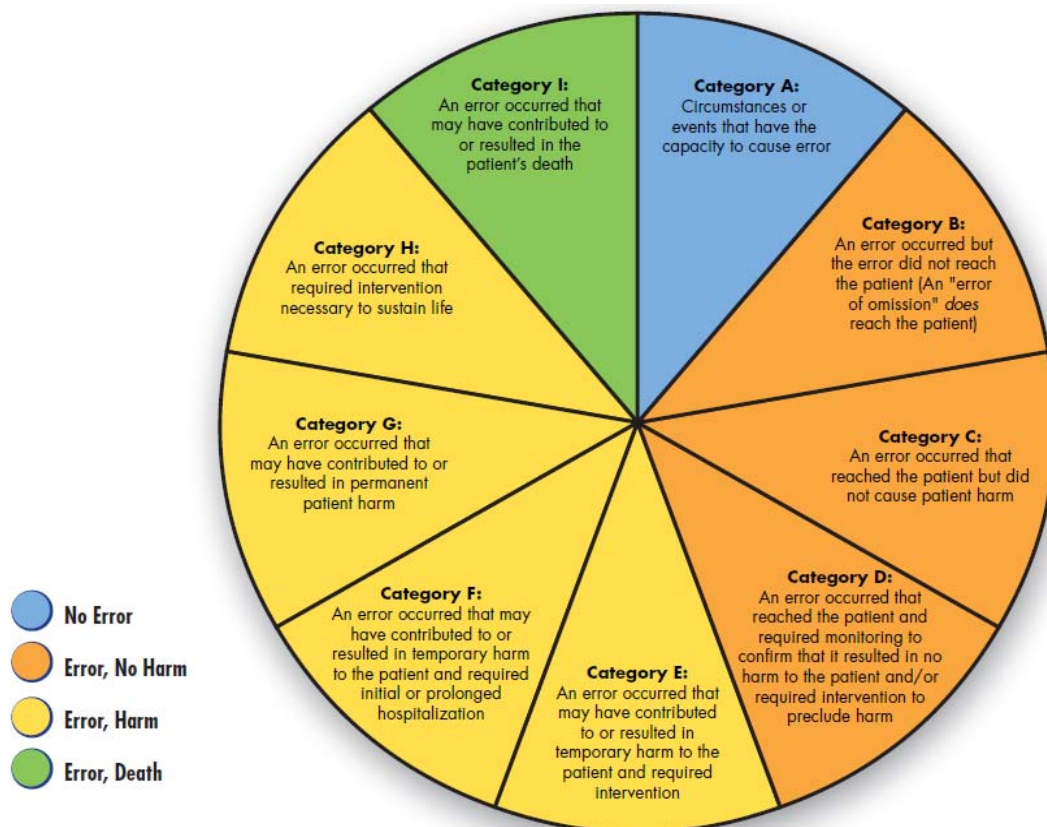
[¥] Domain: S = Structure, P = Process, O = Outcome

- C. A standardized approach to categorizing events in the Voluntary Event Reporting System, for performance improvement purposes, will include the identification of the following type, category and contributory factors (as applicable). Events are referred to the most appropriate manager for evaluation and remediation:

Type	Category	Contributory Factors
Medication	Organization and Management	<ul style="list-style-type: none"> Financial resources and constraints Policy standards and goals Safety culture and priorities
Surgical	Work Environment	<ul style="list-style-type: none"> Staffing levels and mix of skills Patterns in workload and shifts Design, availability, and maintenance of equipment Administrative and managerial support
Diagnostic	Teamwork and Communication	<ul style="list-style-type: none"> Verbal communication Written communication Supervision and willingness to seek help Team leadership
Human Factors	Individual staff member	<ul style="list-style-type: none"> Knowledge and skills Motivation and attitude Physical and mental health
Transition and Handoff	Task	<ul style="list-style-type: none"> Availability and use of protocols Availability and accuracy of test results
Healthcare-Associated Infection	Patient	<ul style="list-style-type: none"> Complexity and seriousness of condition Language and communication Personality and social factors

Reference: Wachter, R.M. 2012. Understanding Patient Safety. The McGraw-Hill Companies, Inc.

- D. Aligned with the National Coordinating Council for Medication Error Reporting and Prevention, each event is classified by the level of harm to the patient. The type of event (from C, above) and the level of harm (below) together constitute an event taxonomy which will be used to track event rates over time.



- E. All events submitted into the electronic medical event reporting system (e-MERS) are to comply with the Adverse Events and Incident Reporting Policy.
 - a. Employees are encouraged to report all events, whether a near miss, adverse event and/or sentinel event.
 - b. Review, follow up and closing of reports is to occur within 30 calendar days (Appendix A).
 - c. Sentinel events may be reported verbally to the Risk Management or to the Executive Medical Director.
- F. Additional sources of information about opportunities for improving patient safety and quality of care include but are not limited to:
 - a) The Risk Management Program, including pending litigation,
 - b) Failure Mode and Effects Analyses (FMEA),
 - c) The Safe Medical Device Reporting Program,
 - d) Administrative databases (e.g. Metropolitan Chicago Health Care Council, Illinois Hospital Association, American Hospital Association, Comp Data, National Practitioners Database, IDPR, Cook County Perinatal Network),
 - e) Patient Relations Reports, and
 - f) Regulatory and Accreditation Surveys (e.g. IDPH, CMS, The Joint Commission).

VIII. Evaluation of Events

- A. Respectful management of clinical adverse events is evidenced by the following elements to those most directly affected, which includes patients as well as employees (as they can be victims too):
 - a) Empathy,
 - b) Disclosure,
 - c) Support,
 - d) Assessment,
 - e) Resolution,
 - f) Learning, and
 - g) Improvement.
- B. All events, whether determined to be a sentinel event or adverse event, that are directed by the Executive Medical Director for further investigation via a root cause analysis will be analyzed as follows:
 - a. Preliminary investigation includes a review of the Event Form for RCA Consideration (Appendix B) and the voluntary event reporting system (if applicable).
 - b. RCA Process ideally includes Three Meetings:
 - 1. *Meeting 1* initiates with a review of the RCA Ground Rules and Guidelines (Appendix C) and includes discussion of sequence of events, identification of actions taken at or near the time of the event, and suggestions of causes and solutions with all team members associated with the event using the RCA Meeting Form (Appendix D). Prior to Meeting 2, a drill down of the event with select team members is conducted to better understand “why” and “how” the event occurred via the RCA Contributory Factor Tree diagram (Appendix E).
 - a. Code each ‘cause’ with “insufficient data,” “non-contributory,” or “contributory”.
 - b. Assign team members to obtain any missing data.
 - 2. *Meeting 2* includes a review of the RCA Contributory Factor Tree associated with the event. Generate at least one corrective action or improvement for each “contributory” factor.
 - a. Check for omissions, better organization and more logical flow.
 - b. Prior to Meeting 3, complete the RCA Analysis and Action Plan Framework (Appendix F).
 - 3. *Meeting 3* includes a review of the event sequence, the RCA Contributory Factor Tree diagram, and the RCA Analysis and Action Plan. The meeting should include, at minimum, Leadership of the involved departments, all involved personnel, Risk Management, and the Quality Department. Specific tasks and timelines are assigned at this meeting.

- C. Aligned with the Quality Plan and The Joint Commission's RCA framework and the Sentinel Events Policy, immediate investigation of sentinel events should begin within 48 hours and Meeting 1 of the RCA is to be scheduled in 7 days. A 30-day time period from the event, or from becoming aware of the event, to complete an acceptable root cause analysis (Appendix G) is required.
- D. As an in-depth internal investigation, a root cause analysis, will be considered acceptable if it has the following characteristics:
 - a) Applies all elements of the RCA Process: Ground Rules and Guidelines document,
 - b) Includes participation by the Leadership of the organization and by the individuals most closely involved in the processes and systems under review,
 - c) Considers any relevant literature, and
 - d) Includes documentation and reporting of patient safety improvement activities by the accountable Department Leader at the Hospital Wide Oversight Committee meeting(s) until the Committee determines the corrective actions are closed.
- E. Documentation and Reporting of Patient Safety Improvement Activities:
 - a. Reports reflecting performance results or progress on patient safety projects and initiatives will utilize common templates for reporting. These templates are used in the spirit of creating user-friendly reports that reflect a systematic approach to improvement. Such templates include but are not limited to:
 - i. Performance dashboards;
 - ii. Analysis and action plans;
 - iii. Control charts for monitoring and evaluation (i.e. tracking and trending); and
 - iv. Ongoing professional practice evaluation.
 - b. Documentation of improvement activities supports both a disciplined, comprehensive approach to improvement and accountable reporting. The focus of the documentation is to share learning and to support replication and safe practices.
 - c. Documentation will be maintained in accordance with the organization's policy on confidentiality of quality improvement information.
- F. Relevant findings from proactive risk assessments and root cause analyses, including effectiveness and safety of services provided, may be considered for:
 - c. Reappraisal/reappointment of medical staff members;
 - d. The renewal or revision of the clinical privileges of mid-level practitioners who practice independently or under supervision of physicians; and
 - e. Performance appraisals of employees.
 - f. Provider peer review process and/or OPPE/FPPE as described in the Medical Staff Bylaws.

IX. Communication and Education

- A. Hospital staff members receive information regarding the hospital's mission, vision, values and quality activities through hospital and departmental orientation, staff meetings, and other forms of communication as appropriate.
- B. The Department of Quality and Patient Safety coordinates patient safety and quality improvement activities.
- C. The Department of Quality and Patient Safety works to improve communication and collaboration around patient safety efforts by identifying opportunities for collaboration between committees and working to minimize and eliminate variation in care. The Department of Quality and Patient Safety acts as an in-house consultant to leadership, staff, and Medical Staff. It also provides direct support and logistical coordination for regulatory compliance activities.
- D. The Department of Quality and Patient Safety arranges with each department to provide the department with action plans and risk mitigation strategies which are generated from events reported by members of the department.

- E. The President of the Medical Staff, or designee, coordinates reporting in regards to practitioner-specific findings of the peer review, credentialing and OPPE/FPPE process. The Medical Staff Office works to communicate patient safety initiatives to the medical staff at large.

X. Recognition

- A. A “Good Catch” Program will be established to encourage the identification of potential system errors or problems before they reach the patient and/or cause harm.
 - a. Goals of the program will be to:
 - i. Strengthen the culture of safety.
 - ii. Allow staff to be recognized for their contributions.
 - iii. Create a learning culture through a non-punitive environment.
 - b. A “good catch” is recognition of an event or circumstance which had the potential to cause an incident or critical incident but which did not occur due to corrective action and/or other timely intervention following recognition. A near miss may be submitted as a “good catch”.
 - c. All “good catches” will be reviewed by the Patient Safety Council based on the following criteria:
 - i. Impact on patient safety.
 - ii. Impact on quality of patient care.
 - iii. Impact on service (timeliness, efficiency, effectiveness).
 - iv. Opportunity to spread and increase positive impact across the organization.
 - d. The program will recognize employees, at minimum, on a quarterly basis.
- B. Additional recognition programs are under discussion and may be instituted in alignment with the Quality Plan and Patient Safety Plan.

XI. Approval of Plan

The Board of Directors approves the Patient Safety Plan after review and approval by the Board’s Quality and Patient Safety Committee and the Hospital Medical Staff’s Executive Medical Staff Committee.

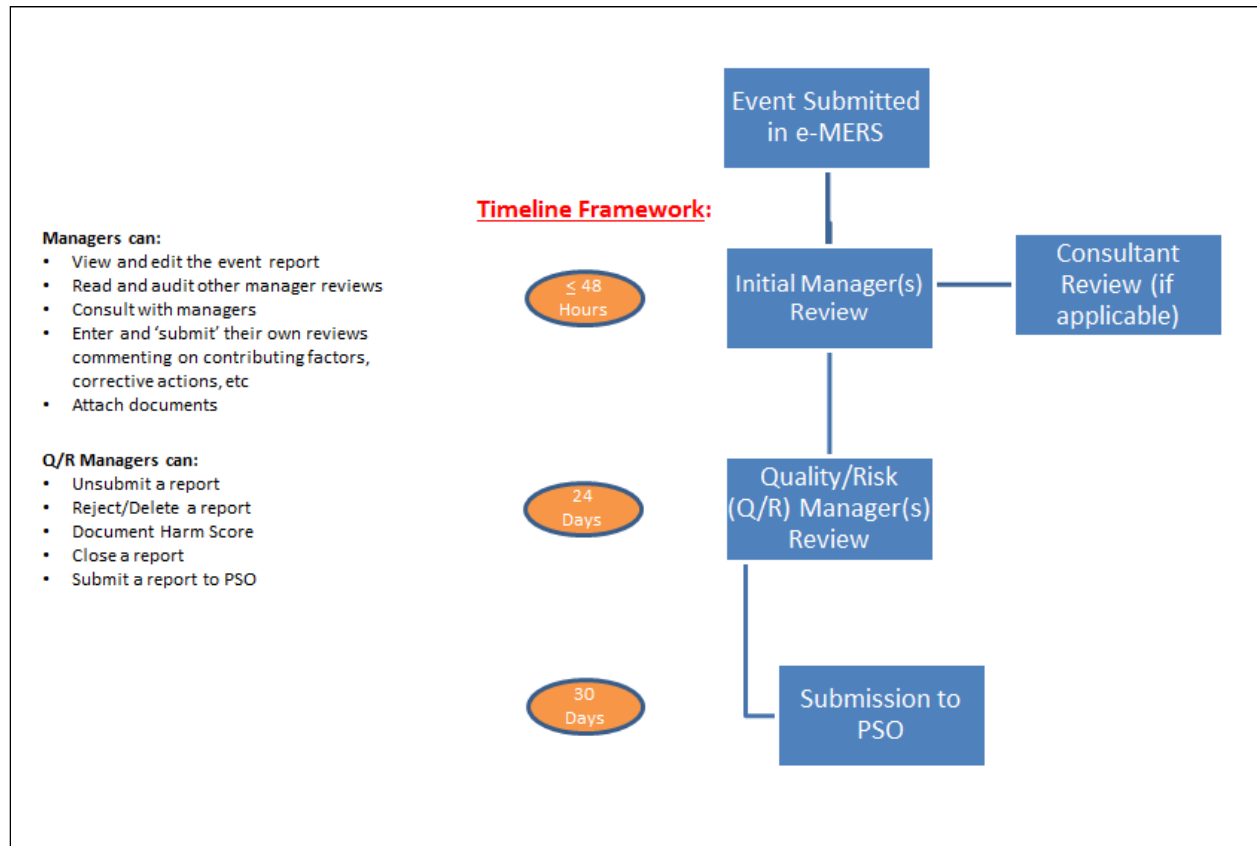
XII. Confidentiality

All information and data generated relating to the activities delineated in the Patient Safety Plan are used to evaluate and improve performance and the quality of patient care and services. The confidential nature of the information will be respected according to the guidelines and parameters established by the federal Health Quality Improvement Act and State of Illinois Medical Studies Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used for quality data reporting.

Every individual involved with performance improvement will follow administrative policy regarding the disclosure of confidential clinical and management information.

XIII. Appendices

Appendix A
John H. Stroger, Jr. Hospital
e-MERS Event Report Workflow



Appendix B
John H. Stroger, Jr. Hospital
Event Form for Root Cause Analysis Consideration

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY

Toni Preckwinkle • President
Cook County Board of Commissioners
David Carvalho • Chairman
Cook County Health & Hospitals System Board
Jorge Ramirez • Vice Chairman
Cook County Health & Hospitals System Board
Ram Raju MD, MBA, FACS, FACHE • CEO
Cook County Health & Hospitals System
John Jay Shannon, M.D. • Interim COO
Inpatient Services
Cook County Health & Hospitals System



Health & Hospitals System Board Members
Commissioner Jerry Butler
Edward L. Michael
Rev. Calvin S. Morris, PhD
Luis Muñoz, MD
Heather E. O'Donnell
Carmen Velasquez
Dorene P. Wiese, EdD

MEMORANDUM

Date: May 9, 2014
To: Department Oversight Committee
From: Krishna Das, MD, Chief Quality Officer
RE: Oversight Case Review OCC-__-14

On behalf of Cook County Health and Hospital System and the Quality Improvement and Medical Oversight Committees of your facility I am requesting your review of the care of this patient:

Initials: **MR#:** **Date(s) of Event:**

Summary of Issues to be addressed:

Please address: -

We would appreciate your response within the next 30 days or following your next Oversight Committee meeting. Please address any issues in care provided by your department, any description of sentinel events or latent errors ('near misses') and corrective actions that will be undertaken by your Department.

Please send the response to me in writing: Department of Quality, Room 421, Administration Building, 1900 W. Polk Street, Chicago, IL 60612 or by FAX to 312-864-9722. See language below in italics and copy and paste into all correspondence. **Please do not email any responses.**

Cc: Claudia Fegan, MD, Executive Medical Director

All information provided in these appended materials is compiled at the direction of the Department of Quality and Patient Safety and is privileged and confidential to be used solely in the course of internal quality control and for the purpose of reducing morbidity and mortality and improving the quality of patient care.

1901 West Harrison Street • Chicago, Illinois 60612 • (312) 864-6000 • TDD (312) 864-0100

• Ambulatory & Community Health Network • Cermak Health Services • Cook County Department of Public Health •
• John H. Stroger, Jr. Hospital • Oak Forest Health Center • Provident Hospital • Ruth M. Rothstein CORE Center •

We Bring HealthCARE to Your Community

Appendix C
John H. Stroger, Jr. Hospital
Root Cause Analysis Process: Ground Rules and Guidelines

A Root Cause Analysis (RCA) is a systematic investigation technique that uses information gathered during an intense assessment of an undesirable event to determine the underlying reasons for the deficiencies or failures. The goal of the RCA is to identify the basic deficiencies or failures in a process that, if eliminated or corrected, would prevent a similar event from recurring.

- RCAs are designed to answer 3 questions:
 1. What happened?
 2. Why did it happen?
 3. What can be done to prevent it from happening again?
- RCAs focus on processes, not people.
- The RCA process is:
 1. Non-punitive (no blaming) and
 2. Considers special causes (clinical processes) to common causes (organizational processes).
- During the process, we keep asking ‘Why?’ to determine where redesign might reduce risk.
- The focus is on changes that could be made in processes and systems – either through redesign or development of new systems or processes – to reduce the risk of such events occurring in the future.
- The RCA process recognizes:
 1. Human Factors most directly associated with the sentinel event and
 2. Risk points (points in a process that are susceptible to failure or breakdowns).

Reference: Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants[®]

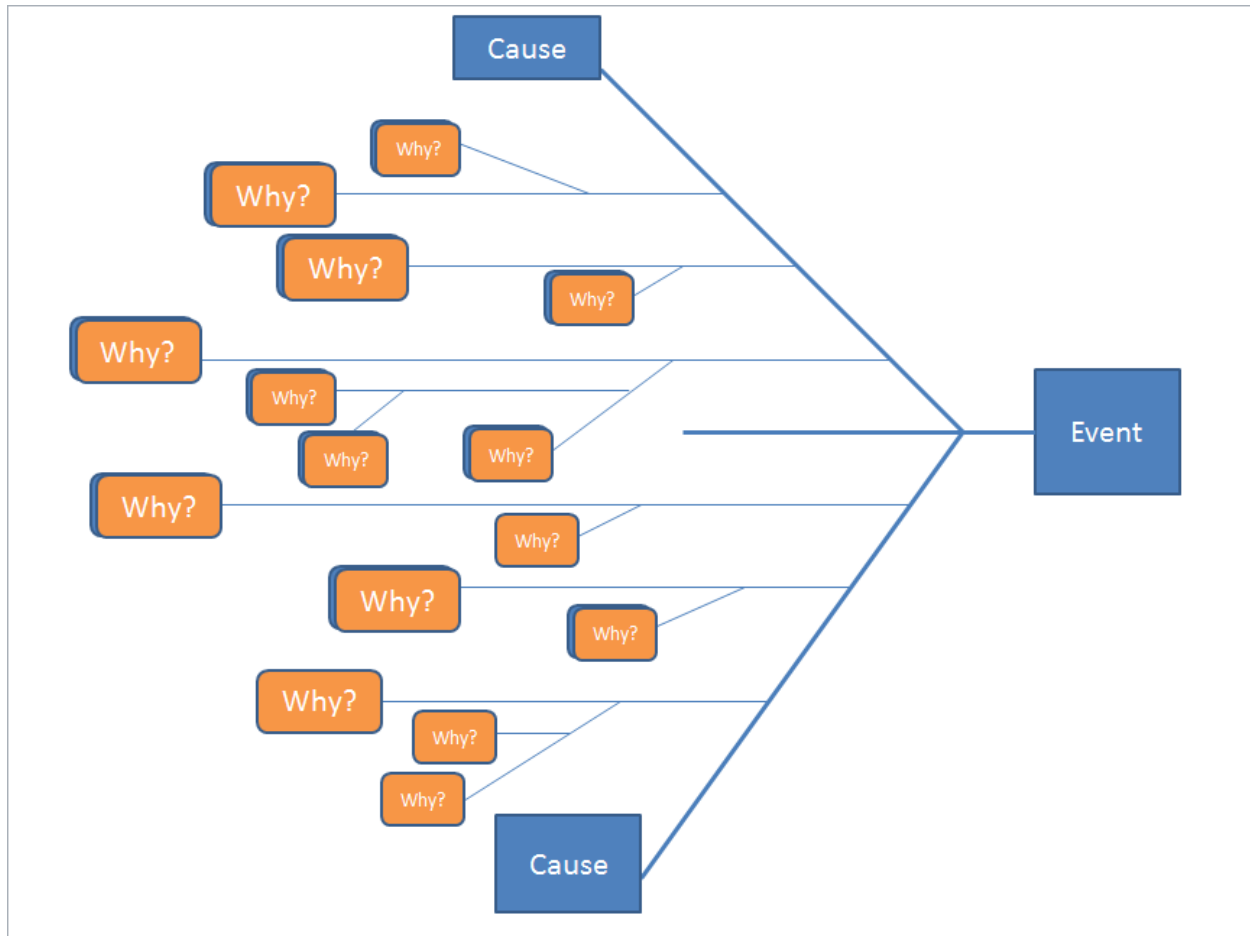
Appendix D
John H. Stroger, Jr. Hospital
RCA Meeting Form

Medical Record # _____ Date of Event: _____ Date of RCA: _____

Sequence of Event	Corrective Actions Taken (at or near the time of the event)	“Parking Lot” (e.g. causes, solutions)

Reference: Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants®

Appendix E
John H. Stroger, Jr. Hospital
RCA Contributory Factor Tree



References: Doggett, A. 2005. Root Cause Analysis: A Framework for Tool Selection. QMJ Vol. 12, No. 4.
Mooney, B. 2000. Sentinel Events & Root Cause Analysis. American Health Consultants[®]

Appendix F
John H. Stroger, Jr. Hospital
ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

CASE IDENTIFIER:

DATE OF RCA:

PARTICIPATION:

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question #. For each finding continue to ask “Why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots”.

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “Why?” question such as “Why did it contribute to the likelihood of the event” or “Why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered “Yes” for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

All information provided in these appended materials is compiled at the direction of the Department of Quality and Patient Safety and is privileged and confidential to be used solely in the course of internal quality control and for the purpose of reducing morbidity and mortality and improving the quality of patient care.

When did the event occur?

Date:	Day of the week:	Time:
-------	------------------	-------

Detailed Event Description Including Timeline:

--

Diagnosis:

--

Medications:

--

Autopsy Results:

--

Past Medical/Psychiatric History:

--

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
1	What was the intended process flow?	<p>List the relevant process steps as defined by the policy, procedure, protocol, or guidelines in effect at the time of the event. You may need to include multiple processes.</p> <p>Note: The process steps <i>as they occurred in the event</i> will be entered in the next question.</p> <p>Examples of defined process steps may include, but are not limited to:</p> <ul style="list-style-type: none"> • Site verification protocol • Instrument, sponge, sharps count procedures • Patient identification protocol • Assessment (pain, suicide risk, physical, and psychological) procedures 			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
		<ul style="list-style-type: none"> Fall risk/fall prevention guidelines 			
2	Were there any steps in the process that did not occur as intended?	Explain in detail any deviation from the intended processes listed in Analysis Item #1 above.			
3	What human factors were relevant to the outcome?	<p>Discuss staff-related human performance factors that contributed to the event. Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> Boredom Failure to follow established policies/procedures Fatigue Inability to focus on task Unintentional blindness/ confirmation bias Personal problems Lack of complex critical thinking skills Rushing to complete task Substance abuse Trust 			
4	How did the equipment performance affect the outcome?	<p>Consider all medical equipment and devices used in the course of patient care, including AED devices, crash carts, suction, oxygen, instruments, monitors, infusion equipment, etc. In your discussion, provide information on the following, as applicable:</p> <ul style="list-style-type: none"> Descriptions of biomedical checks Availability and condition of equipment Descriptions of equipment with multiple or removable pieces Location of equipment and its accessibility to staff and patients Staff knowledge of or education on 			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
		<p>equipment, including applicable competencies</p> <ul style="list-style-type: none"> • Correct calibration, setting, operation of alarms, displays, and controls 			
5	What controllable environmental factors directly affected this outcome?	<p>What environmental factors within the organization’s control affected the outcome? Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> • Overhead paging that cannot be heard • Safety or security risks • Risks involving activities of visitors • Lighting or space issues <p>The response to this question may be addressed more globally in Question #17. This response should be specific to this event.</p>			
6	What uncontrollable external factors influenced this outcome?	Identify any factors the organization cannot change that contributed to a breakdown in the internal process, for example natural disasters.			
7	Were there any other factors that directly influenced this outcome?	List any other factors not yet discussed.			
8	What are the other areas in the organization where this could happen?	<p>List all other areas in which the potential exists for similar circumstances. For example:</p> <ul style="list-style-type: none"> • Inpatient surgery/outpatient surgery • Inpatient psychiatric care/outpatient psychiatric care <p>Identification of other areas within the organization that have the potential to impact patient safety in a similar manner. This information will help drive the scope of your action plan.</p>			
9	Was the staff properly qualified and currently competent for their responsibilities at the time of the event?	<p>Include information on the following for all staff and providers involved in the event. Comment on the processes in place to ensure staff is competent and qualified. Examples may include but are not limited to:</p> <ul style="list-style-type: none"> • Orientation/training • Competency assessment (What competencies do the staff have and how do you evaluate them?) • Provider and/or staff scope of practice concerns • Whether the provider was credentialed and 			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
		<p>privileged for the care and services he or she rendered</p> <ul style="list-style-type: none"> • The credentialing and privileging policy and procedures • Provider and/or staff performance issues 			
10	How did actual staffing compare with ideal levels?	<p>Include ideal staffing ratios and actual staffing ratios along with unit census at the time of the event. Note any unusual circumstance that occurred at this time. What process is used to determine the care area’s staffing ratio, experience level and skill mix?</p>			
11	What is the plan for dealing with staffing contingencies?	<p>Include information on what the organization does during a staffing crisis, such as call-ins, bad weather or increased patient acuity. Describe the organization’s use of alternative staffing. Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> • Agency nurses • Cross training • Float pool • Mandatory overtime • PRN pool 			
12	Were such contingencies a factor in this event?	<p>If alternative staff were used, describe their orientation to the area, verification of competency and environmental familiarity.</p>			
13	Did staff performance during the event meet expectations?	<p>Describe whether staff performed as expected within or outside of the processes. To what extent was leadership aware of any performance deviations at the time? What proactive surveillance processes are in place for leadership to identify deviations from expected processes? Include omissions in critical thinking and/or performance variance(s) from defined policy, procedure, protocol and guidelines in effect at the time.</p>			
14	To what degree was all the necessary information available when needed? Accurate? Complete? Unambiguous?	<p>Discuss whether patient assessments were completed, shared and accessed by members of the treatment team, to include providers, according to the organizational processes. Identify the information systems used during patient care. Discuss to what extent the available patient information (e.g. radiology studies, lab results or medical record) was clear and sufficient to provide</p>			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
		an adequate summary of the patient’s condition, treatment and response to treatment. Describe staff utilization and adequacy of policy, procedure, protocol and guidelines specific to the patient care provided.			
15	To what degree was the communication among participants adequate for this situation?	Analysis of factors related to communication should include evaluation of verbal, written, electronic communication or the lack thereof. Consider the following in your response, as appropriate: <ul style="list-style-type: none"> • The timing of communication of key information • Misunderstandings related to language/cultural barriers, abbreviations, terminology, etc. • Proper completion of internal and external hand-off communication • Involvement of patient, family and/or significant other 			
16	Was this the appropriate physical environment for the processes being carried out for this situation?	Consider processes that proactively manage the patient care environment. This response may correlate to the response in question 6 on a more global scale. What evaluation tool or method is in place to evaluate process needs and mitigate physical and patient care environmental risks? How are these process needs addressed organization-wide? Examples may include, but are not limited to: <ul style="list-style-type: none"> • alarm audibility testing • evaluation of egress points • patient acuity level and setting of care managed across the continuum, • preparation of medication outside of pharmacy 			
17	What systems are in place to identify environmental risks?	Identify environmental risk assessments. <ul style="list-style-type: none"> • Does the current environment meet codes, specifications, regulations? • Does staff know how to report environmental risks? • Was there an environmental risk involved in the event that was not previously identified? 			

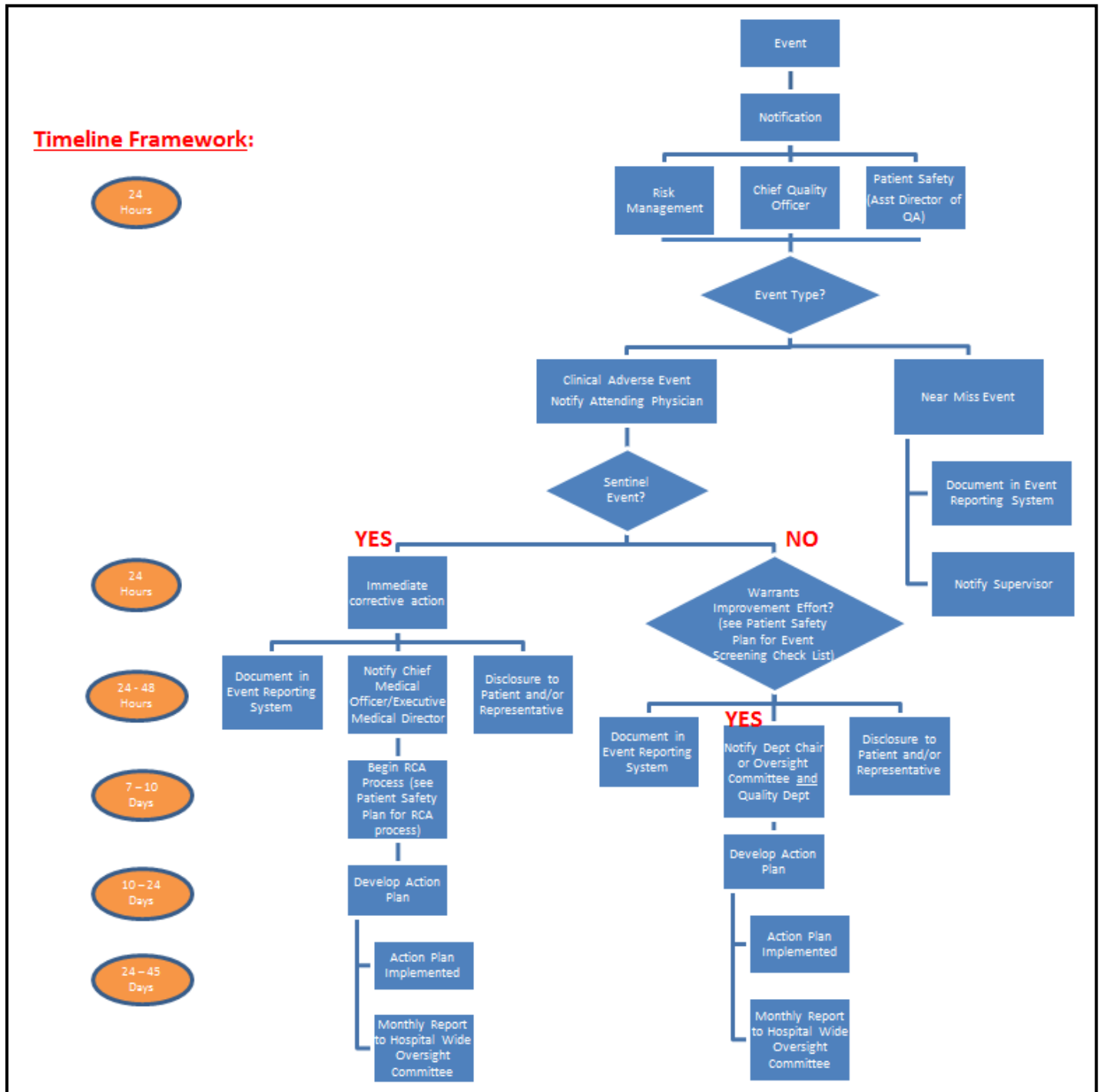
#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
18	What emergency and failure- mode responses have been planned and tested?	<p>Describe variances in expected process due to an actual emergency or failure mode response in connection to the event.</p> <p>Related to this event, what safety evaluations and drills have been conducted and at what frequency (e.g. mock code blue, rapid response, behavioral emergencies, patient abduction or patient elopement)?</p> <p>Emergency responses may include, but are not limited to:</p> <ul style="list-style-type: none"> • Fire • External disaster • Mass casualty • Medical emergency <p>Failure mode responses may include, but are not limited to:</p> <ul style="list-style-type: none"> • Computer down time • Diversion planning • Facility construction • Power loss • Utility issues 			
19	How does the organization’s culture support risk reduction?	<p>How does the overall culture encourage change, suggestions and warnings from staff regarding risky situations or problematic areas?</p> <ul style="list-style-type: none"> • How does leadership demonstrate the organization’s culture and safety values? • How does the organization measure culture and safety? • How does leadership establish methods to identify areas of risk or access employee suggestions for change? • How are changes implemented? 			
20	What are the barriers to communication of potential risk factors?	<p>Describe specific barriers to effective communication among caregivers that have been identified by the organization. For example, residual intimidation or reluctance to report co-worker activity.</p> <p>Identify the measures being taken to break down barriers (e.g. use of SBAR). If there are no barriers to communication discuss how this is known.</p>			
21	How is the prevention of	Describe the organization’s adverse outcome			

#	Analysis Question	Prompts	Root Cause Analysis Findings	Root cause (yes/no)	Plan of Action (“Yes” for any finding that can reasonably be considered for a risk reduction strategy)
	adverse outcomes communicated as a high priority?	procedures and how leadership plays a role within those procedures.			
22	How can orientation and in-service training be revised to reduce the risk of such events in the future?	Describe how orientation and ongoing education needs of the staff are evaluated and discuss its relevance to event. (e.g. competencies, critical thinking skills, use of simulation labs, evidence based practice, etc.)			
23	Was available technology used as intended?	Examples may include, but are not limited to: <ul style="list-style-type: none"> • CT scanning equipment • Electronic charting • Medication delivery system • Tele-radiology services 			
24	How might technology be introduced or redesigned to reduce risk in the future?	Describe any future plans for implementation or redesign. Describe the ideal technology system that can help mitigate potential adverse events in the future.			

Action Plan	Organization Plan of Action Risk Reduction Strategies	Position/Title Responsible Party	Method: Policy, Education, Audit, Observation & Implementation
<p>For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. OR. ...</p> <p>If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.</p> <p>Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.</p> <p>Consider whether pilot testing of a planned improvement should be conducted.</p> <p>Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.</p>	<u>Action Item #1:</u>		
	<u>Action Item #2:</u>		
	<u>Action Item #3:</u>		
	<u>Action Item #4:</u>		
	<u>Action Item #5:</u>		
	<u>Action Item #6:</u>		
	<u>Action Item #7:</u>		
	<u>Action Item #8:</u>		

Reference: The Joint Commission, 2013. The RCA Framework.

Appendix G
John H. Stroger, Jr. Hospital
Event Process and Timeline Framework



Cook County Health and Hospitals System
Minutes of the Quality and Patient Safety Committee Meeting
September 23, 2014

ATTACHMENT #2

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Toni Preckwinkle
President

Cook County Board of Commissioners

John Jay Shannon, MD

Chief Executive Officer

Cook County Health & Hospitals System



**Cook County Health & Hospitals System
Board Members**

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Commissioner Jerry Butler • Vice Chairman

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Lewis M. Collens

Ada Mary Eugenheim

Wayne M. Lerner, DPH, FACHE

Rev. Calvin S. Morris, PhD

Luis Muñoz, MD, MPH

Jorge Ramirez

Carmen Velasquez

Dorene P. Wiese, EdD

Ozuru O. Ukoha, MD

President,

Executive Medical Staff

John H. Stroger Jr. Hospital

of Cook County

September 18, 2014

Dear members of the Quality and Patient Safety Committee:

Please be advised that the Executive Medical Staff of John H. Stroger Jr. Hospital of Cook County, at its September 9, 2014 meeting, has recommended the actions on the enclosed list. It is being presented to you for your consideration

Respectfully

A handwritten signature in black ink, appearing to read "Ukoha".

Ozuru O. Ukoha, MD

President, EMS

John H. Stroger, Jr. Hospital of Cook County



Medical Staff and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Avinashi, Aalok., MD Appointment Effective:	Pediatrics/Neonatology September 23, 2014 thru September 22, 2016	Active Physician
Bruce, Benjamin, MD Appointment Effective:	Surgery/Orthopaedic September 23, 2014 thru September 22, 2016	Active Physician
Camren, Gerald Paul, MD Appointment Effective:	Radiology September 23, 2014 thru September 22, 2016	Active Physician
Clark, Laurel MD Appointment Effective:	Psychiatry September 23, 2014 thru September 22, 2016	Active Physician
Garcia-Gonzalez, Jose, MD Appointment Effective:	Surgery/Ophthalmology September 23, 2014 thru September 22, 2016	Voluntary Physician
Gordon, Katrina MD Appointment Effective:	Family Medicine September 23, 2014 thru September 22, 2016	Active Physician
Joshi, Kiran, MD Appointment Effective:	Family Medicine/Public Health September 23, 2014 thru September 22, 2016	Active Physician
Kacey, Daniel J., MD Appointment Effective:	Surgery/Surgical Critical Care September 23, 2014 thru September 22, 2016	Active Physician

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology

Akintorin, Abayomi, MD Reappointment Effective:	Peds Anesthesia October 5, 2014 thru October 4, 2016	Active Physician
Hosseinian, Mohammad, MD Reappointment Effective:	Anesthesia October 19, 2014 thru October 18, 2016	Affiliate Physician
Jackson, Michele, MD Reappointment Effective:	Anesthesia October 19, 2014 thru October 18, 2016	Affiliate Physician
Johnson, Kimberly, MD Reappointment Effective:	Anesthesia October 19, 2014 thru October 18, 2016	Affiliate Physician
Kirby, Marlon, MD Reappointment Effective:	Anesthesia October 19, 2014 thru October 18, 2016	Affiliate Physician
Waghray-Penmetcha, Taruna, MD Reappointment Effective:	Pain Management October 19, 2014 thru October 18, 2016	Active Physician

Department of Emergency Medicine

Aks, Steven, MD Reappointment Effective:	Emergency Medicine October 21, 2014 thru October 20, 2016	Active Physician
Bryant, Sean, MD Reappointment Effective:	Emergency Medicine October 20, 2014 thru October 19, 2016	Active Physician

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications
Department of Emergency Medicine (continued)

Moskoff, Jordan, MD	Emergency Medicine	Active Physician
Reappointment Effective:	October 18, 2014 thru October 17, 2016	

Department of Family Medicine

Azmat, Awais, MD	Family Medicine	Active Physician
Reappointment Effective:	October 15, 2014 thru October 14, 2016	
Dolan, Margaret, MD	Family Medicine	Voluntary Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	

Department of Medicine

Ambler, Ambika, MD	Endocrinology	Active Physician
Reappointment Effective:	October 16, 2014 thru October 15, 2016	
Atten, Mary Jo, MD	Gastroenterology	Active Physician
Reappointment Effective:	October 17, 2014 thru October 16, 2016	
Baru, Joshua S., MD	Hospital Medicine	Active Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Block, Joel, MD	Rheumatology	Voluntary Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Case, John, MD	Rheumatology	Active Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Clarke, Peter, MD	General Medicine	Active Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Conover, Craig S., MD	Infectious Diseases	Voluntary Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Doukky, Rami, MD	Adult Cardiology	Active Physician
Reappointment Effective:	October 16, 2014 thru October 15, 2016	
Engel, George H., MD	Dermatology	Active Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Golzar, Yasmeen A., MD	Adult Cardiology	Active Physician
Reappointment Effective:	October 16, 2014 thru October 15, 2016	
Gomez Valencia, Javier A., MD	ACHN	Voluntary Physician
Reappointment Effective:	October 16, 2014 thru October 15, 2016	
Hodownec, Aimee C., MD	Infectious Diseases	Voluntary Physician
Reappointment Effective:	October 16, 2014 thru October 15, 2016	
Irons, Sharon, MD	ACHN	Active Physician
Reappointment Effective:	October 21, 2014 thru October 20, 2016	
Mathew, Suja, MD	General Medicine	Active Physician
Reappointment Effective:	October 17, 2014 thru October 16, 2016	

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications
Department of Medicine (continued)

Mohiuddin, Reshma F., DO Reappointment Effective:	ACHN October 16, 2014 thru October 15, 2016	Active Physician
Norlock, Frances, DO Reappointment Effective:	General Medicine October 16, 2014 thru October 15, 2016	Active Physician
Pierko, Krzysztof, MD Reappointment Effective:	Hospital Medicine October 16, 2014 thru October 15, 2016	Active Physician
Reid, David C., MD Reappointment Effective:	Dermatology September 23, 2014 thru September 22, 2016	Active Physician
Rodriguez, Sergio H., MD Reappointment Effective:	ACHN October 17, 2014 thru October 16, 2016	Active Physician
Rogers, Susan F., MD Reappointment Effective:	Hospital Medicine November 19, 2014 thru November 18, 2016	Voluntary Physician
Rohr, Louis, MD Reappointment Effective:	General Medicine October 17, 2014 thru October 16, 2016	Active Physician
Saksena, Franklin B., MD Reappointment Effective:	Adult Cardiology October 21, 2014 thru October 20, 2016	Voluntary Physician
Smith, Pamela, MD Reappointment Effective:	General Medicine November 13, 2014 thru November 12, 2016	Active Physician
Sonenthal, Kathy, MD Reappointment Effective:	Pulmonary Medicine October 17, 2014 thru October 16, 2016	Voluntary Physician

Department of Obstetrics and Gynecology

Gerber, Susan E., MD Reappointment Effective:	Maternal Fetal Medicine September 23, 2014 thru September 22, 2016	Voluntary Physician
Radwanski, Ewa, MD Reappointment Effective:	Reproductive Endocrinology October 04, 2014 thru October 03, 2016	Consulting Physician

Department of Pediatrics

Barrios, Felipe, MD Reappointment Effective:	Neonatology October 19, 2014 thru October 18, 2016	Service Physician
Boyer, Kenneth, MD Reappointment Effective:	Peds Medicine September 28, 2014 thru September 27, 2016	Consulting Physician
Fordwor-Koranteng, Ama, MD Reappointment Effective:	Neonatology September 23, 2014 thru September 22, 2016	Service Physician
Marshall, Jacqueline Hampton, MD Reappointment Effective:	ACHN September 23, 2014 thru September 22, 2016	Active Physician
Pyati, Suma, MD Reappointment Effective:	Neonatology September 28, 2014 thru September 22, 2016	Voluntary Physician

John H. Stroger, Jr. Hospital of Cook County
Reappointment Applications
Department of Pediatrics (continued)

Rak, Melanie, MD Reappointment Effective:	Physical Medicine & Rehab October 21, 2014 thru October 20, 2016	Voluntary Physician
Siffermann, Emily, MD Reappointment Effective:	Child Protective Services October 21, 2014 thru October 20, 2016	Voluntary Physician

Department of Radiology

Apushkin, Michael, MD Reappointment Effective:	Radiology October 18, 2014 thru October 17, 2016	Active Physician
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Department of Surgery

Anderson-Nelson, Susan J., MD Reappointment Effective:	Ophthalmology September 23, 2014 thru September 22, 2016	Active Physician
Fung, Henry Chi Ming, DDS Reappointment Effective:	Oral & Maxillofacial September 28, 2014 thru September 27, 2016	Active Dentist
Kapustiak, James F., MD Reappointment Effective:	Ophthalmology September 23, 2014 thru September 22, 2016	Voluntary Physician
LaVeau, Robert J., DPM Reappointment Effective:	Podiatry September 23, 2014 thru September 22, 2016	Active Podiatrist
Laverdiere Beck, Julie A., DDS Reappointment Effective:	Oral & Maxillofacial September 28, 2014 thru September 27, 2016	Active Dentist
Shah, Ami N., MD Reappointment Effective:	Pediatric Surgery September 28, 2014 thru September 27, 2016	Active Physician

Renewal of Privileges for Non-Medical Staff

Francis, Sarah J., CNP With Muzaffar, Shirin, MD Effective:	Medicine / Pulmonary & Critical Care September 23, 2014 thru September 22, 2016	Nurse Practitioner
Marks, Irene, CNP With Abrego, Fidel, MD Effective:	Ob/Gyne / ACHN September 23, 2014 thru September 22, 2016	Nurse Practitioner
Woods, Robert, PsyD Effective:	Psychiatry / Juvenile Detention Center September 23, 2014 thru September 22, 2016	Clinical Psychologist

Agreement Items

Mathew, Annamma J., CNP With Kulik, Andrew Segovia., MD Effective:	Psychiatry September 23, 2014 thru May 26, 2016	Nurse Practitioner
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Additional Clinical Privileges

Department of Medicine/Core:

Adeyemi, Oluwatoyin, MD	Interpretation of Fibroscan Data
French, Audrey, MD	Interpretation of Fibroscan Data
Huhn, Gregory, MD	Interpretation of Fibroscan Data

Department of Surgery

Cull, John D., MD	Surgery / Surgical Critical Care
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Item IV(C) – September 23, 2014
CCHHS Quality and Patient Safety Committee

John H. Stroger, Jr. Hospital of Cook County (continued)

Medical Staff Status Change With No Change in Privileges

Stanley-Christian, Heather, MD
Mason, Ellen, MD
Pandey, Tanu, MD

Obstetrics and Gynecology
Medicine/General Medicine
Medicine/General Medicine

From Voluntary Physician To Active Physician
From Active Physician To Voluntary Physician
From Active Physician To Voluntary Physician

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Toni Preckwinkle

President

Cook County Board of Commissioners

John Jay Shannon, MD

Chief Executive Officer

Cook County Health & Hospitals System



**Cook County Health & Hospitals System
Board Members**

M. Hill Hammock • Chairman

Commissioner Jerry Butler • Vice Chairman

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Lewis M. Collens

Ada Mary Gugenheim

Wayne M. Lerner, DPH, FACHE

Rev. Calvin S. Morris, PhD

Luis Muñoz, MD, MPH

Jorge Ramirez

Carmen Velasquez

Dorene P. Wiese, EdD

Anwer Hussain, DO, FAAEM

President,

Medical Executive Committee

Provident Hospital

Of Cook County

September 17, 2014

Dear members of the Quality and Patient Safety Committee:

Please be advised that the Medical Executive Committee of Provident Hospital of Cook County, at its September 5, 2014 meeting, has recommended the actions on the enclosed list. It is being presented to you for your consideration.

Respectfully,

A handwritten signature in black ink, appearing to read "Anwer Hussain", written over a horizontal line.

Anwer Hussain, DO

President, MEC

Provident Hospital of Cook County



Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee

INITIAL APPOINTMENT APPLICATIONS

Bamba, Sonya, MD Appointment Effective:	Surgery / Ophthalmology September 23, 2014 thru September 22, 2016	Affiliate Physician
Haddadin, Ramez I., MD Appointment Effective:	Surgery / Ophthalmology September 23, 2014 thru September 22, 2016	Affiliate Physician
Skondra, Dimitra, MD Appointment Effective:	Surgery / Ophthalmology September 23, 2014 thru September 22, 2016	Affiliate Physician

REAPPOINTMENT APPLICATIONS

Department of Anesthesiology

Hosseinian, Mohammed, MD Reappointment Effective:	Anesthesiology October 19, 2014 thru October 18, 2016	Active Physician
Jackson, Michele, MD Reappointment Effective:	Anesthesiology October 19, 2014 thru October 18, 2016	Active Physician
Johnson, Kimberly, MD Reappointment Effective:	Anesthesiology October 19, 2014 thru October 18, 2016	Active Physician
Kirby, Marlon, MD Reappointment Effective:	Anesthesiology October 19, 2014 thru October 18, 2016	Active Physician

Department of Emergency Medicine

Allegretti, Paul, DO Reappointment Effective:	Emergency Medicine October 19, 2014 thru October 18, 2016	Active Physician
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